SPECIFIC INSTRUCTIONS
(continued)

PAGE 5 ADJUSTMENTS TO COSTS (continued)

Adj. #7 HOME OFFICE - ADMINISTRATIVE

Are those administrative costs allocated to each facility where a central "Home Office" is maintained. Home office administrative costs requiring adjustment (advertising, bad debts, interest expense, etc.) should be adjusted here and not in the other individual administrative cost adjustment lines. A separate schedule detailing what cost or income items make up the adjustment amount must be attached. Records to support this cost allocation must be available for audit by the Medicaid Agency within the State of Delaware upon written notice of such audit.

Adj. #8 HOME OFFICE - CAPITAL

Are those capital costs allocated to each facility where a central "Home Office" is maintained. Such costs include charges for lease costs, mortgage interest, property taxes, depreciation, and other capital costs. Home office capital costs requiring adjustment should be adjusted here and not in the other individual capital cost adjustment lines. A separate schedule detailing what cost or income items make up the adjustment amount must be attached. Records to support this cost allocation must be available for audit by the Medicaid Agency within the State of Delaware upon written notice of such audit.

Adj. #9 INTEREST PAID TO RELATED PARTIES - ADMINISTRATIVE

Is a non-allowable cost for Medicaid Reimbursement purposes. Regulation 42 CFR 405.419 states that "Necessary and proper interest on both current and capital indebtedness is an allowable cost". Furthermore, this regulation states "Proper (interest) requires that interest: Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization". Thus, interest paid by the provider to partners, stockholders or related organizations of the provider would not be allowable and should be adjusted out for Medicaid reimbursement purposes. Note that only interest on working capital loans should be adjusted here.

Adj. #10 INTEREST PAID TO RELATED PARTIES - MORTGAGE

Same restrictions as discussed at Adjustment #9. Note that only interest on loans secured by property, plant and equipment should be adjusted here.

Adj. #11 INVESTMENT INCOME - ADMINISTRATIVE

Regulation 42 CFR 405.419 states "Necessary (interest) requires that the interest be reduced by investment income except where such income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds:. Accordingly, interest expense must be adjusted for investment earnings. Note that only investment income related to Interest - Administrative should be adjusted here.

Adj. #12 INVESTMENT INCOME - MORTGAGE

Same restrictions as discussed at Adjustment #11. Note that only investment income related to Interest - Mortgage should be adjusted here.

Adj. #13 LAUNDRY AND DRY CLEANING

Allowable laundry and linen costs must be reduced by any income received for doing personal laundry and dry cleaning.

Adj. #14 MISCELLANEOUS INCOME

Any miscellaneous income received must be offset against expenses incurred in obtaining that income. Example: any income derived from the sale of patient arts and crafts must reduce the costs of materials and supplies used in the projects.

Adj. #15 OWNER/EXECUTIVE DIRECTOR SALARY

Regulation 42 CFR 405.426 states "A reasonable allowance of compensation for services of owners is an allowable cost, provided the services are actually performed in a necessary function. Compensation includes salaries, benefits, amounts for personal benefit of owner, cost of assets and services which the owner receives from the institution and deferred compensation. Reasonable compensation is that which would ordinarily be paid for comparable services by comparable institutions dependent upon the facts of each situation. Necessary means that had the owner not rendered the services, the institution would have had to employ another person to perform the services. Such services must be pertinent to the operation and sound conduct of the institution."

To be includable in allowable costs, compensation for services rendered as an employee, by a person owning stock in the corporation, or an officer or director must be paid during the cost reporting period in which the compensation is earned or within 75 days thereafter. If payment is not made within this time period, the compensation is not included in allowable costs, either in the period earned or in the period actually paid.

The Medicaid Agency reserves the right to adjust owners compensation retroactively by an amount necessary in order to bring such amount into accordance with the above regulation. As it may not be possible for a facility to calculate the amount of allowable owners compensation by the due date of this report, owners compensation should be detailed on Page 10. If adjustment is necessary, the Medicaid Agency will contact the provider in order to determine allowable compensation based upon the facts of each situation.

Adj. #16 PURCHASE DISCOUNTS

If discounts are netted against the purchase price, no adjustment is necessary. However, if a separate accounting is maintained of purchase discounts received, the total should be offset against allowable administrative costs rather than allocating to each category.

Adj. #17 RENTAL INCOME

Should be offset against costs in the lease cost category if it is from renting any part of the facility for whatever reason.

Adj. #18 SALE OF MEDICAL SUPPLIES

Any revenue received from the sale of medical supplies should reduce the allowable costs in that area.

Adj. #19 SALE OF DRUGS

Any revenue received from the sale of drugs should be used to offset allowable pharmacy (non Rx) costs.

Adj. #20 TAXES ON INCOME

Federal, State and local income taxes are not a reimbursable cost because they are not related to patient care. Any other taxes such as transfer taxes and property taxes on land held for investment are not allowable. Also, any interest or penalties incurred on delinquent taxes are not allowable cost.

Adj. #21 TELEPHONE REVENUES

Any revenues received from telephone charges to patients or employees must offset Administrative - Other expenses.

Adj. #22 TELEVISION REVENUES

Any revenue received from rental of television must reduce Capital Costs - Other.

Adj.#23 VENDING MACHINES

Any income received from vending machines in the facility must offset Capital Costs - Other.

SPECIFIC INSTRUCTIONS
(continued)

OTHER ADJUSTMENTS

As previously mentioned, the above 23 adjustments are not all-inclusive, but are the more common adjustments. Other adjustments necessary to bring the facility costs into conformance with Medicaid Reimbursement Principles should be detailed here. They should be in the same format as 1 - 23 and consecutively numbered.

Any adjustment made on a previous statement of the facility should be considered to determine if the same type of adjustment is applicable. The same would hold for adjustments resulting from prior period audits by the Medicaid Agency. Failure to abide by adjustment is considered fraud.

Note: No offset should reduce allowable costs in any one area to below zero.

PAGE 5 EXPLANATION OF ADJUSTMENTS

All adjustments made on page 4 should be explained here in sufficient detail. The number of the adjustment from page 4 should be entered in the left column. If additional pages are necessary, they should be attached.

PAGE 6 PATIENT DAYS

Line 1 Enter total beds available for use on the first day of the cost reporting period. This would include all beds whether they are occupied, unoccupied or reserved.

Line 2 Enter number of beds added or removed during the cost reporting period and the dates they were added or removed.

Line 3 Enter total beds available for use on the last day of the cost reporting period. This would include all beds whether they are occupied, unoccupied or reserved.

Line 4 Enter total beds available for the year. This is arrived at by multiplying the number of days they were available.

Examples: A facility has 45 beds available at the beginning and at the end of the cost reporting period. There were 365 days in the cost reporting period. Therefore, total bed days available for the period was 16,425 (45 x 365).

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SPECIFIC INSTRUCTIONS
(continued)

PAGE 6 PATIENT DAYS (Continued)

Line 4 (cont.) However, assume in the above example that the cost reporting period is July 1, 1986 through June 30, 1987 (365 days). Furthermore, assume that on January 1, 1987, the facility added 3 more beds. Based upon this, the total bed days available is calculated as follows:

Number of actual days from July 1 - December 31	45 beds x 184 =	8,280
Number of actual days from January 1 - June 30	48 beds (45 + 3) x 181 =	8,688
Total bed days available		16,968

Line 5 GENERAL

A patient day for cost allocation purposes begins at midnight and ends 24 hours later. The midnight to midnight method must be used even if the facility uses a different definition of a patient day for statistical or other purposes. The day of admission is counted as a full day; however, the day of discharge or death is not counted as a patient day. If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

All patient days should be accounted for according to patient class, which reflects the degree of care required by patients, i.e. Class A, B, C, D or E. They should also be accounted for according to who pays the charges, i.e.: Medicaid, Medicare, etc. for each level of service.

Payment is made for reserving beds in long-term care facilities for recipients during their temporary absence for acute care hospitalization up to 14 days per hospitalization in any 30 day period, and for leaves of absence up to 18 days per year. These days should be classified the same as if they were occupied. Reserve bed days will be reimbursed at basic charge and the lowest nursing level.

The facility has the duty to maintain adequate census records in order to facilitate the completion of this section. It is recommended that each facility take at least an actual count of all patients daily. The record of this count would serve as a documentation to support this section.

Line 5A Enter number of Medicaid patient days for the period according to patient class as well as total for the period. This should include reserved bed days for Medicaid patients.

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SPECIFIC INSTRUCTIONS
(continued)

PAGE 6 PATIENT DAYS (Continued)

Line 5B Enter number of Medicare patients for the period according to patient class as well as total for the period. This should include reserved bed days for Medicare patients.

Line 5C Enter number of Private Pay patient days for the period according to patient class as well as total for the period. This should include reserved bed days for Private Pay patients.

Line 5D Enter number of Other patient days not accounted for in 5A, 5B or 5C according to patient class as well as total for the period. This should include reserved bed days not accounted for in 5A, 5B or 5C.

Line 5E Enter total of patient days for each level of service and grand total for period. Grand total should agree with total patient days per census information.

Line 7 Summarize admissions, discharges and deaths for the year. Admissions would include all patients admitted to the facility from outside the facility. Also counted as an admission is the transfer of a patient from one status to another. Example: Mr. Doe was originally admitted to the facility by his family as a private pay patient. After being in the facility for five months, Mr. Doe became eligible for Medicaid benefits. Mr. Doe would be counted as an admission for private pay upon his original admission to the facility. Mr. Doe would also be counted as an admission for Medicaid upon his transfer to Medicaid status from Private Pay.

Discharges would include all patients being discharged from the facility with the exception of those whose bed is being reserved as discussed in Line 5 instructions. As with admissions, a discharge is counted when a patient transfers out of one status and into another. In the example above, Mr. Doe would be counted as a discharge for Private Pay upon his transfer to Medicaid status.

Deaths include all patients that die while a patient of the facility during the period.

PAGES 7, 8, & 9

Any facility may submit a copy of their financial statements corresponding with the cost reporting period in lieu of these three pages as long as the information as reported on the financial statements is detailed enough to include the information as listed on these pages. If the financial statements are not submitted, then these pages must be completed in detail.

SPECIFIC INSTRUCTIONS
(continued)

PAGE 7 BALANCE SHEET

All applicable information should be completed as of the end of the cost reporting period. For all items that indicate that a schedule should be attached, it is expected that such schedule would provide detail as to what comprises that category.

The schedules of Receivables from and Debt Payable to Related Parties should include all details of the receivable/payable. This includes related party name, amount of receivable/payable, interest rate and due date.

The proper portion of the equity section should be completed depending upon the organization type of the facility.

PAGE 8 STATEMENT OF OPERATIONS

This page should be completed from the trial balance of the facility. It does not necessarily correspond to any other part of this statement except where indicated.

PAGE 9 STATEMENT OF REVENUE

Enter sources of revenue as detailed. All revenue received should be accounted for on this page.

PAGE 10 ADDITIONAL INFORMATION

All questions should be answered completely. If any question is not applicable, it should be so indicated.

PAGE 11 OWNER/EXECUTIVE DIRECTOR COMPENSATION

For each person who is considered an owner or executive director of the facility as discussed at Adjustment #15, the following information should be submitted:

Name, percentage of ownership; actual salary paid and/or accrued for the period; cost of benefits provided, such as health insurance, life insurance, pension; other benefits such as value of use of automobile, personal accounting fees, etc.; and average number of hours worked per week during the cost reporting period.

A description of each owners normal duties for which he is responsible should be given to substantiate the salary paid. Attach additional pages if necessary.

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TN 227 Effective date 7/1/87

DELAWARE MEDICAID PROGRAM

ESTIMATE OF THE COST INCREASES INCURRED BY NURSING FACILITY IN MEETING THE REQUIREMENTS OF OBRA '87 AND OBRA '90

I. TRAINING, CERTIFICATION AND CONTINUING EDUCATION FOR NURSE AIDES

	# Aides		Cost/Aide	Total Cost
A. Prior to October 1, 1990				
Competency Evaluation	2041		$50	$102,050
75 hr Training (10%)	204	Avg fee for tng	$160	$32,640
Staff Salaries-Testing	2041	Avg $6.82/hr x 6 hrs	$41	$83,681
-Training	204	Avg $6.82/hr x 75 hrs x 80%	$409	$83,436
Travel Costs	700	$.30/mi x 34 mi / 5 persons	$3	$2,100
Total Cost				$303,907
Cost per Aide				$149
Avg # Aides Per Facility				33
Avg Cost per Facility				$4,914

- o Information from DE Office of Licensing and Certification indicates that most currently employed nurse aides were able to take the certification examination prior to Oct 1, '90 without the 75 hour training program. An estimate of 10% requiring the training is used here.
- o Average staff salaries are derived from the Nurse Wage Survey, July 1989, and projected forward to 1990.
- o Nurse aide training and certification costs will be reimbursed directly as administrative costs from billing submitted by each nursing facility.

B. After October 1, 1990				
Competency Evaluation	680	33% Turnover / year	$50	$34,000
75 hr Training (100%)	680	Avg fee for tng	$160	$108,800
Staff Salaries-Testing	680	Avg $6.82/hr x 6 hrs	$41	$27,880
-Training	680	Avg $6.82/hr x 75 hrs x 80%	$409	$278,120
Travel Costs	230	$.30/mi x 34 mi / 5 persons	$3	$690
Total Cost				$449,490
Cost per Aide				$661
Avg # Aides Per Facility				33
Avg Cost per Facility				$21,813

- o Continuing education for nurse aides will be reported on the annual cost report and will be reimbursed as part of the per diem.
- o Annual staff turn-over estimate of 33% is derived from staffing experience of facilities.

II. ADDITIONAL NURSE STAFF REQUIREMENTS

A. Nursing Staff

1. RN on Day Shift	# Facilities Currently Meeting Requirement	32
	# Facilities That Must Increase Staff to Comply With Requirement	0

- o No financial impact of this additional staff requirement because all facilities are currently meeting minimum staffing requirement.

2. RN/LPN on all shifts	# Facilities Currently Meeting Requirement	29
	# Facilities That Must Increase Staff to Comply With Requirement	3
	Additional Cost per Facility for 3rd Shift	
Total Cost per Facility	1.7 FTE x 2080 hrs/FTE x $15.30/hr Salary/Benefit/Training	$54,101

- o Current reimbursement under the Delaware Patient Index Reimbursement System makes no distinction between Skilled and Intermediate levels of care. The three facilities which must increase their staff to comply with the new regulations have always been paid on the same basis as those facilities which exceeded the new staffing requirement. The nursing time factors in the Medicaid time matrix are sufficient to reimburse for the required staffing.
- o Three of 29 private facilities in Delaware must increase their nursing staff in order to meet the new requirements. Two of the three facilities will continue to receive reimbursement exceeding their costs providing that they maintain their current patient mix. The third facility currently has costs exceeding reimbursement due to several factors. Significant factors include their corporate policy to accept low care patients, their 72% occupancy rate, and higher than average nursing salaries. By making only minor adjustments to the patient mix, this facility could increase the average daily reimbursement per patient from $20.94 to $26.75. Their costs will increase from $22.62 to $26.62 as a result of the additional nursing staff required.

B. Resident Assessment

Avg 87 pts/facility x 25 minutes/pt/year @ $16.98/hr = $615.53 per Facility

- o The PIRS nursing time requirements matrix has been adjusted to account for the additional nursing time required to conduct Resident Assessment. Time for assessment and documentation was originally included in the nursing time requirements for RN and LPN at each level of patient accuity. Additional time will be included when calculating the Oct 1, 1990 rates to account for the new requirements. The amount of time added to the matrix was calculated by estimating the time required for assessment per patient per year and dividing by the number of annual available patient days per patient.

C. Plans Of Care

Avg 87 pts/facility x 30 minutes/pt/year @ $16.98/hr = $738.63 per Facility

- o The PIRS nursing time requirements matrix has been adjusted to account for the additional nursing time required to conduct Plans of Care. Time for plans of care and documentation was originally included in the nursing time requirements for RN and LPN at each level of patient accuity. Additional time will be included when calculating the Oct 1, 1990 rates to account for the new requirements. The amount of time added to the matrix was calculated by estimating the time required for plans of care per patient per year and dividing by the number of annual available patient days per patient.

III. EXTENDED PATIENT SERVICES

A. Dietary: No cost increase is expected as a result of the new requirements. Current State certification standards require the level of Dietary standards required by OBRA. The PIRS reimbursement system will reflect any increase in staffing.

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B. Pharmacy: No cost increase is expected as a result of the new requirements. Current State certification standards require the level of Pharmacy standards required by OBRA. The PIRS reimbursement system will reflect any increase in staffing.

C. Dental Services: Delaware does not currently cover Dental Care under the State Plan. No cost impact is expected.

D. Medical Records: Nursing time for conducting Patient Assessment and coordinating Plans of Care will has been expanded in the Nursing Time Requirements Matrix. This accounts for the additional time required to manage medical records.
Please refer to the explanation of the Additional Nursing Staff Requirements above.

E. Activities Personnel: 8 Facilities - P.T. Activities Director @ $23,400 annually

- o 8 facilities expect to expand their activities staff, although they currently employ an Activities Director.
- o All Delaware facilities currently meet this requirement by employing an an qualified Activities Director on staff. Many facilities also have activities personnel in addition to the Director.
- o The estimates of the number of facilities effected by this requirement and the cost of a part time Activities Director were derived from a telephone survey of 9 facilities and information from the state nursing facilities association.

F. Social Worker:

> 120 beds	4 Facilities - F.T. Social Worker	@ $31,200 annually
< 120 beds	11 Facilities - P.T. Social Worker	@ $23,400 annually

- o 4 of 10 facilities over 120 beds will incur costs to upgrade their social work activities.
- o 11 of 22 facilities under 120 beds must upgrade their social work program by increasing their social work staff.
- o The estimates of the number of facilities effected by this requirement and the cost of Social Workers were derived from a telephone survey of 9 facilities and information from the state nursing facilities association.

G. Physical Therapy:

1753 ICF beds x 90% occupancy = 1578 patients x 20% increase = 316 patients
Therapist treats 6 pts/hr @ avg $35/hr x 2 times/week/pt = $11.67/pt/week
Total Cost 316 patients x $11.67/pt/week = $3,688/week total
Average Cost per Facility 11 pts @ $11.67/pt/week = $128.37/wk = $6,675/yr.

- o On-site therapy will continue to be billed directly as a contracted ancillary service, and will not be part of the per diem reimbursement rate.
- o ICF as well as SNF patients are currently receiving therapy as needed. An increase of about 20% utilization is anticipated, primarily for ICF patients.
- o Estimates of additional costs were derived from information from the Delaware Division of Public Health, Office of Health Facilities Licensing and Certification, and a review of therapy reimbursement.

IV. MEDICAL DIRECTOR

Average $66/hour for contractual services x 5 hours per month
$330 per month x 12 months = $3,960 per year for Medical Director

- o All Delaware nursing facilities are currently required to have Medical Director. Many will need to expand the responsibilities of the designated position.
- o 12 facilities to increase Medical Director hours under contract from an average of $720/ mo to $1050/ mo. Increase represents $3,960 per facility per year.
- o The cost estimate for the Medical Director was based on information from the Medicaid review nurse, who projected the number of hours required and the average hourly reimbursement, and called a number of facilities to determine how this requirement would be met. The number of facilities effected was estimated by the state nursing facilities association.